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Homicide and Suicide Rates — National Violent Death Reporting System, Six States, 2003

In 2003, CDC instituted a new surveillance system, the National Violent Death Reporting System (NVDRS); the system collects detailed information regarding violent deaths from multiple sources. This report describes preliminary 2003 data from the first six states* that participated in NVDRS and compares these data with 1993–2002 data from the National Vital Statistics System (NVSS). The findings indicate a substantial increase in homicide rates among young males from 2002 to 2003 and substantial increases in both homicide and suicide rates among males from 2000 to 2003. These findings underscore the need for states to have timely information for effective violence-prevention programs.

NVDRS is a state-based, active surveillance system that collects information on all homicides, suicides, deaths of undetermined intent, deaths resulting from legal intervention, and deaths from unintentional firearm injuries. State health departments participating in NVDRS typically identify these violent deaths as their death certificates are filed and then establish details of the cases from medical examiner, coroner, and law enforcement records. Details collected include the circumstances contributing to the deaths, interpersonal relationships, and toxicology results. The first six states to join NVDRS in 2003 accounted for 10% of suicides and 11% of homicides in the United States in 2002.

International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths in 2003 have not yet been reported to NVDRS from two of the six states. However, trained coders in each state routinely assign a cause of death to all cases by using standard NVDRS definitions after reviewing information from all available sources. The cause of death, as defined by NVDRS, is consistent with the way most medical examiners and coroners assign cause of death. The NVDRS cause of death used for this analysis was consistent with the underlying cause of death from death certificates in approximately 97% of the homicides and suicides for which ICD-10 codes were available. This analysis was restricted to occurrent deaths (i.e., deaths within the state borders of both residents and nonresidents) because of delays in reporting deaths of state residents that occurred out of state. All NVDRS 2003 data are preliminary.

NVDRS data for 2003 were compared with data for 1993–2002 from NVSS for the same six states. In NVSS, a homicide was defined as a death in which the underlying cause was coded as X85–Y09 or Y87.1; these codes exclude deaths attributed to legal intervention, operations of war, or terrorism (*1*). A suicide was defined as a death in which the underlying cause was coded as X60–X84 or Y87.0. Deaths that occurred in Oregon as a result of its Death with Dignity Act are not classified as suicides by Oregon law and were excluded from this analysis.

Rates were calculated by using intercensal and postcensal bridged-race population estimates compiled by the National Center for Health Statistics (*2*) and were age-adjusted to the 2000 standard U.S. population. Rates were also stratified by sex and age. Because of limited death counts in some age groupings, the age categories were collapsed into ages 0–24 years,

* Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia.

INSIDE

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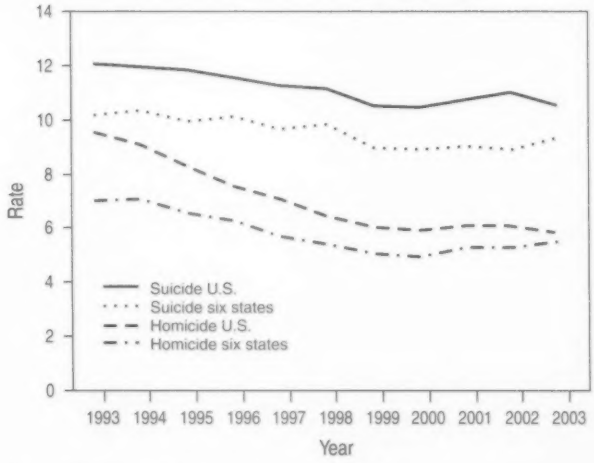
25–64 years, and ≥65 years. Percentage changes in rates from 2002 to 2003 and 95% confidence intervals (CIs) were calculated. Trends in homicide and suicide rates in the six states during 2000–2003 were tested for statistical significance by using Poisson regression analysis.

During 1993–2000, the age-adjusted homicide rate for the six NVDRS states decreased 29%, from 7.0 to 5.0 per 100,000 population (Figure). During 2000–2002, the age-adjusted homicide rate for the same states increased 6%, from 5.0 to 5.3. In 2003, the six states recorded 1,952 homicides, representing a further increase of 4% (95% CI = -2%–11%) above 2002 rates (Table). In four of the six states, homicide rates increased in 2003, but only an increase in New Jersey was statistically significant. The largest increase in rates was among males aged 0–24 years (18%; CI = 5%–32%); young males accounted for nearly all of the overall homicide increase in 2003. During 2000–2003, the trend test for homicide rates was significant, primarily because of the substantial increase in homicides among males aged 0–24 years.

During 1993–2000, the age-adjusted suicide rate for the six states declined 13%, from 10.2 to 8.9 per 100,000 population (Figure). During 2000–2002, the age-adjusted suicide rate was relatively stable in the six states, declining only 0.3%. However, in 2003, NVDRS recorded 3,415 suicides, representing a significant increase of 5% (CI = 0.4%–11%) above 2002 rates (Table). From 2002 to 2003, suicide rates increased in four of six states, but only an increase in Oregon was statis-

FIGURE. Age-adjusted homicide and suicide rates*, by year — United States and six NVDRS states†, 2000–2003



* Per 100,000 population.
† National Violent Death Reporting System. Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia.
§ Rates for 1993–2002 are from the National Vital Statistics System; rates for the six states for 2003 are from NVDRS.

TABLE. Homicide and suicide rates*, by sex and age — six NVDRS states†, 2000–2003

Sex/Age	Annual rates§ 2000	2001	2002	2003	% change from 2002 to 2003 %	(95% CI¶)	Trend test for 2000–2003 rates χ^2	p value
Homicide								
Male								
0–24	8.55	8.83	9.01	10.63	18	(5–32)	13.08	0.0003
25–64	8.52	8.82	8.91	8.87	0	(-10–10)	0.63	0.4262
≥65	2.13	3.17	3.08	2.82	-8	(-38–34)	0.07	0.7846
All ages**	7.70	8.11	8.23	8.71	6	(-2–14)	8.94	0.0028
Female								
0–24	1.94	2.19	2.15	1.91	-11	(-31–15)	0.03	0.8727
25–64	2.46	2.68	2.63	2.67	1	(-15–20)	0.76	0.3822
≥65	1.76	1.91	1.39	1.38	-1	(-38–58)	1.27	0.2602
All ages**	2.20	2.42	2.32	2.26	-2	(-15–12)	0.06	0.8061
Total**	**4.95**	**5.26**	**5.26**	**5.49**	**4**	**(-2–11)**	**7.37**	**0.0066**
Suicide								
Male								
0–24	6.16	5.24	5.56	5.66	2	(-12–18)	1.35	0.2455
25–64	17.47	19.08	18.60	19.42	4	(-2–11)	9.10	0.0026
≥65	27.09	23.69	28.53	27.34	-4	(-15–8)	0.00	0.9790
All ages**	14.94	14.90	15.34	15.56	1	(-4–7)	4.24	0.0394
Female								
0–24	1.03	1.39	1.05	1.01	-4	(-33–37)	0.02	0.8817
25–64	5.57	5.50	4.68	5.78	23	(9–40)	0.34	0.5571
≥65	3.84	3.70	3.76	4.43	18	(-10–54)	0.98	0.3225
All ages**	3.75	3.81	3.28	3.89	19	(7–32)	0.74	0.3909
Total**	**8.92**	**8.99**	**8.89**	**9.37**	**5**	**(0.4–11)**	**4.99**	**0.0255**

* Per 100,000 population.
† National Violent Death Reporting System. Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia.
§ Rates for 2000–2002 are from the National Vital Statistics System; rates for 2003 are from NVDRS.
¶ Confidence interval.
** Age-adjusted.

tically significant. From 2002 to 2003, significant increases were observed among females in all six states combined (19%; CI = 7%–32%) but not among males. However, during 2000–2003, the trend test for suicide rates was significant for males but not for females.

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Editorial Note: During 1993–2000, NVSS data indicate that homicide and suicide rates declined in the United States; the age-adjusted rates of homicide and suicide declined 38% and 13%, respectively. These declines ended with small, consecutive increases in homicide and suicide rates in 2001 and 2002, even after exclusion of the deaths associated with the September 11, 2001, terrorist attacks (*3*). A similar pattern was observed during 1993–2002 in the six NVDRS states. Although preliminary national homicide and suicide rates did not increase in 2003, preliminary rates typically underestimate final rates for these conditions by 3%–4% (*1*). The homicide increase in NVDRS states, however, is consistent with final data from law enforcement reports compiled by the Federal Bureau of Investigation, which indicate an increase in the national homicide rate in 2003 (*4*). The homicide rate increase in NVDRS was caused by a substantial increase in homicides among males aged ≤24 years. Similarly, fluctuations in the national homicide rate in the 1980s and early 1990s were caused by homicides among males aged 15–24 years (*5*).

Although NVDRS collects detailed information about circumstances associated with these deaths, determining how risk factors might have changed in recent years with only 1 year of data was not possible. Changes in rates of violence have been attributed to various risk factors (e.g., changes in the economy, the availability of drugs and weapons, and gang violence) (*5,6*), particularly with respect to homicide. NVDRS will monitor future data for changes in the proportions of violent deaths that involve specific risk factors.

The findings in this report are subject to at least three limitations. First, all death rates were based on deaths by place of occurrence rather than place of residence, and some decedents might not have resided in the six states that provided data. However, 2002 NVSS data indicate that the numbers of resident and occurrent homicides in these six states combined differed by only 1.7%, and the difference was only 0.7% with respect to suicides. Therefore, occurrent deaths are acceptable substitutes for resident deaths. Second, preliminary NVDRS data might differ from final NVDRS data if late cases are added to the system. Third, NVDRS data might differ from data generated from NVSS because the NVDRS classification of a death might differ from the way a death is recorded on a death certificate in a limited number of cases.

Although only six states began collecting data in 2003, NVDRS is now funding programs in 11 additional states[†] to collect data on violent deaths and submit these data to CDC. Further studies using NVDRS data will allow interpretation of broader trends across more states. Analyzing data on the circumstances associated with violent deaths should provide a better understanding of personal and social risk factors for violence and help identify potential prevention opportunities. Reviews of promising strategies conclude that those simultaneously addressing multiple risk factors for violence are most likely to be effective (*7–9*).

Acknowledgments

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[†] Alaska, California, Colorado, Connecticut, Georgia, New Mexico, North Carolina, Oklahoma, Rhode Island, Utah, and Wisconsin.

Assessing the National Electronic Injury Surveillance System – Cooperative Adverse Drug Event Surveillance Project — Six Sites, United States, January 1–June 15, 2004

Adverse drug events (ADEs) occur when therapeutic drugs have injurious effects; current systems for conducting national ADE surveillance are limited, and current national estimates of ADE incidence are problematic (*1*). In 2003, CDC, in collaboration with the Consumer Product Safety Commission (CPSC) and the Food and Drug Administration (FDA), created the National Electronic Injury Surveillance System – Cooperative Adverse Drug Event Surveillance (NEISS-CADES) project by adding active surveillance of ADEs to the National Electronic Injury Surveillance System – All Injury Program (NEISS-AIP). Because ADEs can be more difficult to identify than other injuries, an independent chart review in a sample of six NEISS-CADES hospitals was conducted to evaluate the sensitivity and predictive value positive (PVP) of ADE identification. This report describes the results of that evaluation, which indicated that although PVP for ADEs was high, the sensitivity was low, particularly for certain types of ADEs. As a result of these findings, additional training on identifying and reporting ADEs was initiated for all NEISS-CADES hospital coders. As more persons in the United States use drug therapies, active, postmarketing surveillance of ADEs can help identify safety problems and guide prevention efforts.

NEISS-CADES is a nationally representative subsample of 64 of 98 NEISS hospitals selected as a stratified probability sample of U.S. hospitals with a minimum of six beds and a 24-hour emergency department (ED) (*2*). At each of the 64 hospitals, coders trained by CPSC and CDC staff review all ED charts for ADEs. Coders identify cases by looking for keywords and diagnoses, such as "medication reaction," "overdose," and "adverse effect," and record information into a standardized, computer-based data-entry system. Cases are defined as those occurring in persons who sought ED care for injuries linked by the treating physician to the outpatient use of a drug or drug-specific adverse effects. This case definition excludes drug withdrawal, drug abuse, self-harm attempts, lack of therapeutic effect, and effects of medications administered in the ED. Drugs include prescription medications, over-the-counter medications, vaccines, vitamins, and nutritional supplements.

For this evaluation, a convenience sample of six NEISS-CADES hospitals was selected from 14 hospitals with scheduled site visits in the summer of 2004 and the capability to provide a sufficient number of randomly selected medical charts for review. Hospitals were selected to represent a range of ADE reporting (0.2%–1.7% of ED visits) and a range of hospital sizes* (three very large, one large, one medium, and one small hospital). Large metropolitan (one hospital), smaller metropolitan (three hospitals), and rural areas (two hospitals),† and five of nine U.S. census geographic divisions were represented. The sample did not include any pediatric specialty hospitals. At each hospital, ED charts were retrieved for review from a list of randomly selected dates during the period January 1–June 15, 2004. Up to 1,200 charts or up to 20 days of charts were retrieved on the basis of the ED volume of each hospital. Because of limitations in medical record archiving systems, charts were not retrievable for six (10%) of 61 dates initially selected, and alternate dates were selected as substitutes. Of 4,719 ED visits identified for the dates selected, charts for 4,561 (97%) visits were available for review.

Chart reviewers used the same standardized methodology as coders. Each available chart was reviewed by two reviewers experienced in medical record abstraction and ADE surveillance (i.e., an epidemiologist with training in medical terminology and a physician board-certified in internal medicine) independent of each other and of the NEISS hospital coder. For ADE cases, each reviewer recorded event descriptions and associated drugs. Conflicting reviews were resolved by a third person (a physician board-certified in internal and emergency medicine). A sample kappa statistic was calculated by using statistical software to assess agreement of case identification between the two primary reviewers (*3*). Using the review process described in this report as the "gold standard," sensitivity (i.e., the proportion of cases detected by the surveillance system) and PVP (i.e., the proportion of coder-reported cases that actually had a drug-related event) for the six-hospital composite were calculated by using ratio estimation (*4*). These statistics were calculated as ratio estimates, assuming a stratified cluster sampling design, with hospitals forming strata and dates forming clusters. The charts reviewed from each ED were assigned weights according to the fraction of dates reviewed out of the January 1–June 15 sampling frame and the fraction of cases for which charts were available for each date reviewed.

A total of 68 ADE cases were identified by expert review of the 4,561 ED charts (weighted estimate: 1.4%) (Table). Ten cases were initially identified by only one of two reviewers (seven identified by one reviewer and three identified by the other), with a sample kappa statistic of 0.92 (95% confidence interval [CI] = 0.87–0.97), indicating a high level of nonchance agreement between reviewers. The median age of patients with ADEs was 57 years (range: 15 months–100 years), and 53% were female.

A total of 29 ADE cases had been reported to NEISS-CADES before the charts were reviewed. Of these, 25 were among the 68 ADE cases detected by the reviewers, whereas the remaining four were false-positive cases in which an injury was attributed to a drug in the chief complaint section of the chart but was not confirmed elsewhere in the chart. The weighted estimate of coder sensitivity for ascertaining ADE cases was 0.33 (CI = 0.23–0.44). The weighted estimate of PVP for coder-reported ADEs was 0.92 (CI = 0.85–1.00). The relatively low overall coder sensitivity was attributed in part to low sensitivity for detecting cases of hypoglycemia associated with diabetes agents (three of 16 detected) and bleeding associated with anticoagulants (e.g., warfarin and heparin) (one of nine detected). When a narrower case definition excluding these two types of cases was considered, weighted sensitivity increased to 0.45 (CI = 0.31–0.59), and weighted PVP was 0.94 (CI = 0.85–1.00). As a result of these findings, NEISS-CADES coders are now provided a streamlined flow sheet to identify ADEs and training specifically focused on identifying unintentional overdoses of diabetes agents and anticoagulants.

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Editorial Note: The goal of this evaluation was to assess and improve the usefulness of NEISS-CADES as an ongoing system to provide national estimates of ADEs. Evaluation of new surveillance systems such as NEISS-CADES is a challenging but important task for appropriately interpreting and applying public health surveillance data. If the hospitals in this investigation are representative of other NEISS-CADES hospitals, the PVP of 0.92 indicates that the ADE cases reported

* Hospital size was defined by number of ED visits per year. Very large hospitals had ≥41,131 visits per year; large hospitals had 28,151–41,130 visits per year; medium hospitals had 16,831–28,150 visits per year; and small hospitals had <16,830 visits per year.

† A large metropolitan area was defined as a metropolitan statistical area (MSA) with ≥250,000 population in 2003; a small metropolitan area was defined as an MSA with <250,000 population in 2003; and a rural area was defined as outside of any MSA.

TABLE. Mechanism of injury, injury type, and drug category associated with 68 cases identified through chart review and 25 cases reported from six hospitals — National Electronic Injury Surveillance System – Cooperative Adverse Drug Event Surveillance Project, United States, 2004*

Mechanism of injury (No. of cases by review)	Injury type	Drug category	No. of cases by review	No. of cases reported
Unintentional overdoses (n = 31)	Hypoglycemia	Insulins	11	2
		Oral diabetic agents	5	1
	Bleeding or hypocoagulability	Warfarin	8	0
		Heparin	1	1
	Altered level of consciousness	Opioid analgesics	3	2
	Other injuries	Other agents	3	1
Adverse effects (n = 19)	Cardiovascular	Antihypertensive agents	5	1
	Neurologic	Antidepressants	3	2
		Antipsychotics	1	0
	Gastrointestinal	Antimicrobial agents	2	0
		Other agents	2	1
	Other injuries	Other agents	6	2
Allergic reactions (n = 18)	Rash	Antimicrobial agents	10	5
		Nonopioid analgesics	1	1
	Angioedema	Angiotensin converting enzyme inhibitors	1	0
		Radiologic contrast agents	1	1
	Pruritis	Antimicrobial agents	1	1
		Radiologic contrast agents	1	1
	Anaphylaxis	Antimicrobial agents	1	1
	Injuries not stated	Unknown agents	2	2
Total			**68**	**25**

* Includes cases reported from 4,561 emergency department charts retrieved from randomly selected dates from the period January 1–June 15, 2004.

in NEISS-CADES generally represent actual cases. The low proportion of cases initially identified that were attributed to overdoses of insulin and anticoagulants suggests that national estimates of these events are likely to be lower than the actual number and highlights areas on which to focus interventions. After the implementation of interventions, reevaluation of sensitivity and PVP will be needed to help further improve sensitivity.

The sensitivity of coder case identification reported in this investigation might appear low (0.33 overall; 0.45 if two specific types of ADEs are excluded); however, this result should be considered in the context of other available surveillance data. The most commonly used national surveillance system for ADEs, the FDA Adverse Event Reporting System (AERS), is a passive surveillance system estimated to capture 1%–38% of serious adverse drug reactions and influenced by such factors as length of time the drug has been on the market and media attention (*5*). In addition, AERS was designed to capture newly recognized, unlabeled, adverse events and not designed to capture common ADEs from errors or overprescribing of older drugs, which likely contribute to the greatest public health burden (*6*). The National Hospital Ambulatory Medical Care Survey (NHAMCS) (*7*) has been used to describe outpatient adverse reactions, and the Drug Abuse Warning Network (DAWN) recently modified data-collection procedures to include adverse reactions (*8*); similar assessment of these systems might be appropriate.

The findings in this report are subject to at least three limitations. First, this evaluation was limited to review of available ED patient charts from a sample of days in six of the 64 NEISS-CADES hospitals. These hospitals were chosen as a convenience sample stratified by ADE reporting and size; therefore, although the characteristics of the ADE cases reported are similar to those from other hospitals (*9*), the estimates of sensitivity and PVP might not apply to other hospitals. Second, identification of ADEs by chart review has lower sensitivity for some types of ADEs when compared with other methods, such as screening computer-generated laboratory signals (*10*); however, chart review remains the most feasible method of national surveillance. Finally, surveillance of outpatient ADEs based on ED data does not capture ADEs that were not diagnosed and documented by the treating physician, ADEs diagnosed during subsequent hospitalizations, or ADEs treated elsewhere.

Since publication of the Institute of Medicine report, *To Err Is Human: Building a Safer Health System*, in 1999, considerable attention has been focused on the public health problem of medical injuries and ADEs, especially ADEs that occur in hospitalized patients. However, at least in part because of limited data, the potentially more common problem of ADEs in nonhospitalized persons has not been as fully explored. Nationally representative surveillance data that is both timely and detailed is needed to characterize the public health burden of outpatient ADEs and to help target prevention strategies. NEISS-CADES will continue as a resource for providing ongoing ADE surveillance, and this evaluation will assist in interpretation and use of these public health data.

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This report is based, in part, on data contributed by six National Electronic Injury Surveillance System hospitals. T Schroeder, MS, C Irish, R Colucci, Div of Hazard and Injury Data Systems, Consumer Product Safety Commission. R Wagner, R Sattin, Div of Injury and Disability Outcomes and Programs, National Center for Injury Prevention and Control, CDC.

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Congenital Malaria — Nassau County, New York, 2004

Human malaria is a parasitic disease caused by four distinct species of intraerythrocytic protozoa of the genus *Plasmodium*. The parasites are transmitted to persons by the bite of an infective female *Anopheles* mosquito and rarely through blood transfusion and congenital transmission (*1,2*). The majority of malarial infections reported in the United States are acquired abroad by recent immigrants or persons returning from areas where malaria is endemic (*3,4*). This report describes the first documented case of congenital malaria acquired in Nassau County, New York, which is the fifth case of congenital malaria reported in the United States since 2000 (*5–8*). Health-care providers should consider malaria as a diagnosis in neonates and young infants, particularly those with fever, whose mothers emigrated from areas where malaria is endemic.

In April 2004, a previously well male infant aged 7 weeks born in Nassau County was hospitalized with a 1-day history of low-grade fever. The infant had been born at full term in an uncomplicated vaginal delivery; birthweight was 6 pounds, 14 ounces, and his APGAR scores were 9/9 (out of 10, at 1 minute and 5 minutes after birth). On admission to the hospital, the infant was placed on antibiotic treatment, and a laboratory evaluation was performed for a presumptive diagnosis of sepsis by using bacterial cultures of blood, urine, and cerebrospinal fluid (CSF) and viral cultures of CSF; however, the cultures yielded negative results, and no cause was identified. On the third day of hospitalization, antibiotics were discontinued, the infant had no fever, and he was discharged. Laboratory testing indicated hemoglobin of 9.2 g/dL (normal: 10.0 g/dL–14.3 g/dL) and a white blood cell count of 6,300 cells/μL (normal: 6,000 cells/μL–17,500 cells/μL).

On follow-up 5 days after discharge, the infant had no symptoms or signs of illness except for a hemoglobin measurement of 6.2 g/dL with a hematocrit of 18% (normal: 29.3%–42.2%). Peripheral smears revealed malarial parasites (parasitemia <1% of red blood cells); morphology was consistent with *Plasmodium vivax*. The infant was immediately readmitted to the hospital. Treatment with the recommended dose of chloroquine was well tolerated, and the infant was transfused with 75 mL (15 mL/kg of patient body weight) of packed red blood cells before discharge. His hemoglobin at discharge was 11 g/dL, and he had negative smears for malarial parasites.

Investigation by the Nassau County Department of Health revealed that the mother had emigrated from Guatemala in June 2003 and since then had not traveled outside the United States. The risk assessment questionnaire used by her prenatal

provider did not include a question regarding history of malaria. In November 2003, during her fifth month of pregnancy, the mother telephoned her health-care provider to report a 1-day history of fever, myalgia, and headache. Two days later, she went to a local emergency department with headache, sore throat, and rhinorrhea. She was discharged with a diagnosis of upper respiratory infection. No laboratory or other studies were performed.

After malaria was diagnosed in the infant, blood was collected from the mother the same day; the sample was negative for malarial parasites on blood films but positive for *P. vivax* DNA by polymerase chain reaction. She was prescribed chloroquine and primaquine. One month later, the mother was interviewed in Spanish, her native language; she stated that she had malaria diagnosed 2 years earlier in Guatemala and was treated with an unknown therapy. She told interviewers she had one relapse while residing in Guatemala. She could not recall the date of her relapse, nor the type of treatment.

Reported by: *B Doraiswamy, MD, Nassau Univ Medical Center, East Meadow; A Genovese-Candela, MBA, Nassau County Dept of Health, Mineola, New York.*

Editorial Note: Malarial infection or relapse during pregnancy poses substantial risks to the mother and fetus, including risks for maternal anemia, spontaneous abortion, perinatal mortality, low birthweight, and prematurity (*1,3*). Pregnancy is known to be a common cause of relapse with *P. vivax* and *P. ovale* (*4*). Recurrences of any partially or improperly treated species of *Plasmodium* might be caused by the natural immune suppression that is characteristic of pregnancy (*8*). Diagnosis can be complicated by the nonspecific clinical presentation of this disease (*1,4*). Practitioners in areas where malaria is not endemic often fail to consider malaria in their initial differential diagnoses (*9*). In an immigrant, diagnosis of malaria is further complicated because many immigrants have partial immunity, possibly resulting in longer incubation periods and more subtle, nonspecific symptoms (*1*). In a newborn, signs and symptoms of malaria, including fever, poor appetite, irritability, and lethargy, can mimic sepsis, further obscuring the diagnosis (*3*).

According to the Pan American Health Organization, malaria remains endemic in 21 countries of the Americas, including Guatemala, the country of origin for the mother described in this report. *P. vivax* is the predominant malarious parasite in the Americas, accounting for 71% of cases in the 21 countries with transmission and 97% of cases in Guatemala in 2001 (*10*).

Practitioners should ask immigrant patients their country of origin, date of immigration, and dates of any return travel to their home country (*4*). Practitioners should also be aware of information resources regarding the global distribution of infectious diseases of clinical importance (http://www.cdc.gov/travel). In the rare case of congenital transmission described in this report, language and cultural barriers might have posed obstacles to disclosure by the pregnant mother of her history of malaria to her health-care provider. When feasible, medical history forms completed by a patient in any health-care setting should be available in the patient's native language and should include conditions and diseases of epidemiologic importance. CDC recommends that malaria be considered in the differential diagnosis of illness in 1) persons with fever and a history of travel to areas where malaria is endemic, including immigrants, refugees, migrant laborers, and international travelers; 2) fever of unknown origin, regardless of travel history; and 3) ill neonates and young infants, particularly those with fever and immigrant mothers, regardless of the interval between the mother's immigration and delivery (*2,8*). Additional information regarding diagnosis of malaria is available at http://www.dpd.cdc.gov/dpdx.

Acknowledgments

The findings in this report are based, in part, on contributions by A Greenberg, MD, D Kuhles, MD, M Sherman, C Cabello, MPH, Nassau County Dept of Health, Mineola; M Anand, MPH, J Ennis, A Teal, B Wallace, MD, P Smith, MD, New York State Dept of Health.

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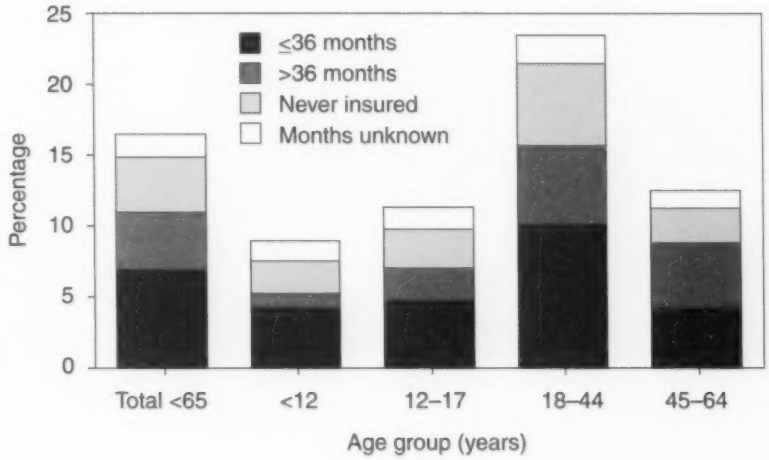
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Persons Aged <65 Years Without Health Insurance, by Age Group and Number of Uninsured Months — United States, 2003



Among the 16.5% of persons aged <65 years who were without health insurance at the time of the interview, approximately one fourth had never had health insurance, and an additional one fourth had been without health insurance for >36 months. Being without health insurance for a lengthy period is associated with less access to preventive health-care services and decreased continuity of care for chronic conditions.

SOURCE: Schiller JS, Adams PF, Coriaty Nelson Z. Summary health statistics for the U.S. population: National Health Interview Survey, 2003. Vital Health Stat 2005;10(224): In press. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_224.pdf.

Notice to Readers

Africa Malaria Day — April 25, 2005

Every 30 seconds, a child in Africa dies from malaria; of the estimated 1 million malaria deaths occurring each year worldwide, 90% occur in Africa, primarily among young children (*1,2*). To confront this public health problem, heads of state and representatives from 44 African countries met in Abuja, Nigeria, on April 25, 2000, and signed the Abuja Declaration (*3*), which committed their countries to decreasing malaria deaths in Africa by 50% by 2010. This event is commemorated every year on Africa Malaria Day and offers an annual opportunity to raise the world's awareness of Africa's fight against malaria.

The Abuja goal is achievable; malaria is preventable and curable, effective tools and strategies are already used to combat malaria (e.g., drugs, insecticide-treated bed nets, and indoor insecticide spraying), research is under way to improve current tools and strategies and develop new ones (e.g., vaccines), and the global community offers increasing financial and technical support to fight malaria.

To mark Africa Malaria Day 2005, major events will be held in locations worldwide, including Lusaka, Zambia; Washington, DC; and Brussels, Belgium. This year's theme, "Unite Against Malaria," and the associated slogan, "Together We Can Beat Malaria," underscore the importance of collaboration among all stakeholders, as exemplified by the Roll Back Malaria Partnership, a global partnership initiated by the World Health Organization, United Nations Development Programme, United Nations Children's Fund, and World Bank in 1998, that works with governments, other development agencies, nongovernmental organizations, and private-sector companies to reduce the human and socioeconomic costs of malaria.

Africa Malaria Day 2005 is also an occasion to take stock of progress midway to the 2010 goal. The Abuja Declaration proposed an intermediate target to be reached by 2005: 60% of people suffering from, or at risk for, malaria having access to treatment and protective measures. Evaluating the extent to which this interim target has been reached will guide efforts toward halving malaria deaths by 2010.

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Notice to Readers

Autism Awareness Month — April 2005

April is Autism Awareness Month. Autism spectrum disorders are lifelong developmental disabilities characterized by unusual social and communication development and the presence of unusual or repetitive behaviors and interests (*1*). These conditions affect as many as 2–6 per 1,000 children in the United States (*2,3*), making autism a serious public health concern. Children with autism identified early and enrolled in early intervention programs show significant improvements in their language, cognitive, social, and motor skills, as well as in their future educational placement (*4,5*). In collaboration with a coalition of partners, CDC recently launched a public awareness campaign, "Learn the Signs. Act Early." to educate parents about early childhood development, including potential early warning signs of autism and other developmental disabilities.

To track rates and trends in autism and conduct epidemiologic studies, CDC funds monitoring programs in 18 states and supports five Centers for Autism and Developmental Disabilities Research and Epidemiology (CADDRE). The CADDRE centers are conducting a large-scale, epidemiologic case-control study of autism to examine potential risk factors. Additional information about autism activities is available at http://www.cdc.gov/ncbddd/autism or http://www.cdc.gov/actearly.

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Notice to Readers

National STD Awareness Month — April 2005

April is National Sexually Transmitted Diseases (STDs) Awareness Month, a health observance created to increase awareness about STDs, including their transmission, prevention, and treatment. STDs continue to be a major health threat in the United States, especially among adolescents and young adults. CDC estimates that 19 million new STD infections occur annually, nearly half of them among persons aged 15–24 years (*1*). Untreated STDs can lead to potentially severe and costly health consequences. Annual direct medical costs of STDs among persons aged 15–24 years are estimated at $6.5 billion (*2*).

STDs are preventable, and many are easily treated and cured. However, the majority of adolescents and young adults are not adequately screened for STDs. This is especially true for two of the most common STDs, chlamydia and gonorrhea. Both are easily treated, but because they are often asymptomatic (especially in females), screening is necessary to detect infection. In 2003, only 29% of young women aged 16–25 years in commercial managed health-care plans were screened for chlamydia, compared with breast and cervical cancer screening rates of approximately 75% (*3*). CDC and professional organizations such as the American Medical Association recommend that all sexually active women aged ≤25 years receive screening for chlamydia each year (*4*). Advances in diagnostic technology, including tests that can evaluate urine and vaginal swab specimens, enable screening for STDs in various settings, including school-based clinics and community-based organizations. Additional information regarding chlamydia and other STDs is available at http://www.cdc.gov/std.

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Notice to Readers

CDC Announces Landmark Reorganization

As the world copes with 21st-century health threats such as terrorism, avian influenza, and the unrelenting stresses of modern life, CDC has taken a landmark step in its readiness to confront these challenges. After notification by the U.S. Department of Health and Human Services on April 5, 2005, the U.S. Congress officially accepted CDC's plans for internal restructuring, making it official on April 21. These proposed changes will enable CDC to pursue its mission in preparing for new and unpredictable health threats and protecting the health and quality of life of all U.S. residents throughout their lives.

CDC is also changing to keep up with more complex health concerns such as childhood asthma, AIDS, catastrophic natural disasters, and a barrage of global health threats. During its most recent major transformation nearly 20 years ago, CDC had approximately 4,000 employees and a budget of $411 million. Today, its combined workforce of employees and contractors totals nearly 14,000, with a budget of approximately $8 billion. The agency is changing to meet 21st-century challenges such as new technology, complex information flow, and rising health-care costs. Change also includes modernizing its management and accountability to realize tangible savings that can go directly to science and programs that affect public health.

This modernization involves a new organizational structure, including a framework for four new coordinating centers that will help CDC scientists combine their expertise to solve public health problems, streamline the flow of information for leadership decision-making, and better leverage the expertise of CDC partners. CDC has also added two new centers to focus on health informatics and health marketing, which are vital in translating scientific data into usable information and health messages that help U.S. residents make sound health decisions. Additional information about the reorganization of CDC is available at http://www.cdc.gov/od/oc/media.

Errata: Vol. 54, No. 10

In the report, "Trends in Tuberculosis — United States, 2004," on page 246, the last sentence of the first full paragraph should read as follows: "Of these seven states, two reported increases in cases and rates for 2004 (Texas, 4.0% increase in rate per 100,000 population; and Florida, 1.0%); the other five states reported decreases in cases and rates (California, 8.4% decrease in rate per 100,000 population; Georgia, 2.5%; Illinois, 10.9%; New Jersey, 3.3%; and New York, 7.3%)."

Also on page 246, errors occurred in the second, third, and fourth footnotes. The second and third footnotes should begin as follows:

"§ States reporting declines in cases and rates in 2004 (number of cases, % decrease in rates per 100,000 population from 2003 to 2004):"

"¶ States/areas reporting increases in cases and rates in 2004 (number of cases, % increase in rates per 100,000 population from 2003 to 2004):"

The fourth footnote, should read as follows:

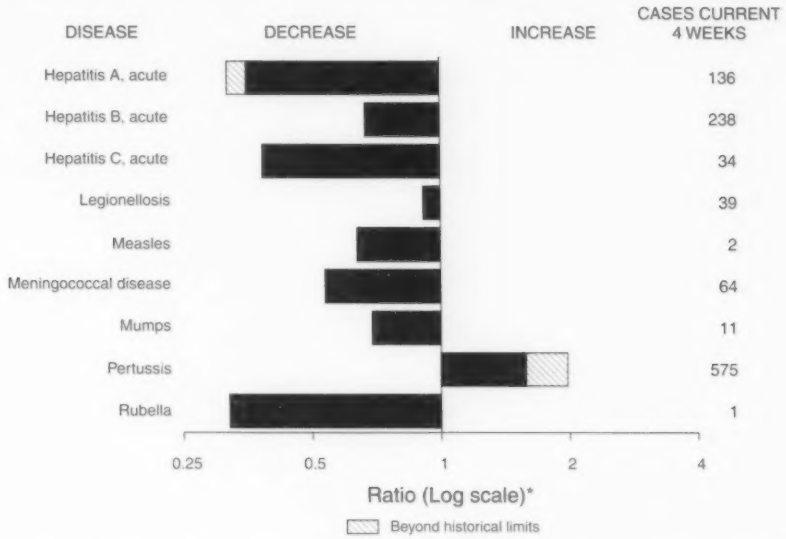
"** States reporting the same number of cases and declines in rates in 2004 (number of cases, % decrease in rates per 100,000 population from 2003 to 2004) were Hawaii (116, 1.1%), Oregon (106, 0.8%), and Delaware (32, 1.5%)."

On page 247, in Figure 1, errors occurred in the shading used to indicate the rate range groups for three states. The shading should indicate the following: Maine, ≤1.7 per 100,000 population; New Hampshire, 1.8–2.8; and Pennsylvania, 1.8–2.8.

Erratum: Vol. 54, No. 14

In the QuickStats, "Life Expectancy at Birth, by Year — United States, 1970–2003," on page 363, the ethnic identifier "non-Hispanic" was incorrectly used to describe the four populations represented in the figure. The populations should have been described as: white female, black female, white male, and black male. Persons in these populations were of any ethnicity.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals April 16, 2005, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending April 16, 2005 (15th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	28	15
Botulism:			HIV infection, pediatric†¶	104	72
foodborne	4	3	Influenza-associated pediatric mortality†**	29	—
infant	11	23	Measles	10††	14§§
other (wound & unspecified)	6	2	Mumps	69	55
Brucellosis	15	27	Plague	—	—
Chancroid	9	11	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis†	3	2
Cyclosporiasis†	8	96	Q fever†	14	15
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	5	7
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	2	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	33	50
human granulocytic (HGE)†	21	19	Tetanus	2	2
human monocytic (HME)†	22	16	Toxic-shock syndrome	26	32
human, other and unspecified †	6	1	Trichinellosis¶¶	6	—
Hansen disease†	9	27	Tularemia†	3	5
Hantavirus pulmonary syndrome†	3	3	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update March 27, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 10 cases reported, six were indigenous and four were imported from another country.
§§ Of 14 cases reported, five were indigenous and nine were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	10,042	8,762	235,094	262,065	1,218	1,525	451	708
NEW ENGLAND	406	311	7,314	8,823	—	—	29	37
Maine	3	5	660	561	N	N	3	6
N.H.	2	10	547	489	—	—	4	10
Vt.¶	1	8	292	341	—	—	8	5
Mass.	211	84	4,162	4,015	—	—	9	10
R.I.	34	33	976	1,007	—	—	1	1
Conn.	155	171	677	2,410	N	N	4	5
MID. ATLANTIC	1,995	1,292	28,062	32,793	—	—	65	121
Upstate N.Y.	188	132	5,820	6,104	N	N	19	22
N.Y. City	1,137	381	8,491	10,460	—	—	13	36
N.J.	357	386	3,040	5,347	N	N	4	9
Pa.	313	393	10,711	10,882	N	N	29	54
E.N. CENTRAL	915	804	35,419	47,940	2	5	76	182
Ohio	136	227	8,156	11,990	N	N	35	42
Ind.	119	116	5,780	5,185	N	N	4	26
Ill.	482	281	10,305	13,728	—	—	—	28
Mich.	135	131	6,275	11,831	2	5	14	38
Wis.	43	49	4,903	5,206	N	N	23	48
W.N. CENTRAL	227	218	13,419	16,297	3	4	61	74
Minn.	69	45	2,506	3,310	3	N	17	30
Iowa	18	9	1,533	1,968	N	N	14	11
Mo.	99	100	6,373	6,060	—	3	22	15
N. Dak.	5	11	254	515	N	N	—	—
S. Dak.	5	—	802	744	—	—	2	8
Nebr.¶	2	8	404	1,585	—	1	—	1
Kans.	29	45	1,547	2,115	N	N	6	9
S. ATLANTIC	3,395	3,420	45,763	49,562	—	—	107	140
Del.	51	41	932	867	N	N	—	—
Md.	406	340	4,786	5,561	—	—	5	7
D.C.	176	148	1,084	1,079	—	—	1	2
Va.¶	177	135	6,497	6,530	—	—	10	15
W. Va.	19	29	640	811	N	N	4	2
N.C.	298	236	9,611	7,861	N	N	12	29
S.C.¶	133	203	5,794	5,561	—	—	5	5
Ga.	503	509	4,159	9,515	—	—	31	44
Fla.	1,632	1,779	12,260	11,777	N	N	39	36
E.S. CENTRAL	581	442	16,637	15,059	—	3	9	34
Ky.	70	41	3,290	1,657	N	N	2	7
Tenn.¶	232	187	6,082	6,418	N	N	2	12
Ala.¶	168	124	1,555	3,724	—	—	4	9
Miss.	111	90	5,710	3,260	—	3	1	6
W.S. CENTRAL	1,021	1,290	31,769	33,028	—	2	13	24
Ark.	69	44	2,524	2,259	—	1	—	7
La.	170	279	5,289	7,288	—	1	2	—
Okla.	72	36	3,084	2,950	N	N	7	7
Tex.¶	710	931	20,872	20,531	N	N	4	10
MOUNTAIN	398	253	15,525	14,558	789	973	28	29
Mont.	3	—	618	425	N	N	1	2
Idaho¶	3	2	701	917	N	N	1	2
Wyo.	—	3	331	311	—	—	2	2
Colo.	83	47	3,601	3,549	N	N	10	15
N. Mex.	42	20	748	2,275	2	8	2	1
Ariz.	166	104	6,416	4,754	761	939	3	5
Utah	20	19	1,224	894	2	7	4	1
Nev.¶	81	58	1,886	1,433	24	19	5	1
PACIFIC	1,104	732	41,186	44,005	424	538	83	67
Wash.	106	127	5,637	5,014	N	N	5	—
Oreg.¶	66	50	2,403	2,271	—	—	8	7
Calif.	897	517	30,903	33,886	424	538	50	59
Alaska	7	7	1,103	1,115	—	—	—	—
Hawaii	28	31	1,140	1,719	—	—	—	1
Guam	1	—	—	270	—	—	—	—
P.R.	259	142	1,246	634	N	N	N	N
V.I.	7	2	32	117	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update March 27, 2005.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	264	265	36	49	43	33	3,959	4,501	78,887	91,837
NEW ENGLAND	18	11	8	12	8	2	381	381	1,341	2,065
Maine	—	—	1	—	—	—	41	35	41	83
N.H.	2	2	1	—	—	—	13	16	39	36
Vt.	1	—	—	—	—	—	45	22	11	23
Mass.	4	3	1	4	8	2	161	204	842	926
R.I.	1	1	—	—	—	—	21	23	152	271
Conn.	10	5	5	8	—	—	100	81	256	726
MID. ATLANTIC	32	23	3	3	1	10	733	991	8,160	10,557
Upstate N.Y.	14	6	3	1	—	3	246	254	1,774	2,048
N.Y. City	1	6	—	—	—	—	192	337	2,079	3,305
N.J.	9	2	—	1	—	4	90	124	1,150	1,961
Pa.	8	9	—	1	1	3	205	276	3,157	3,243
E.N. CENTRAL	55	63	5	11	3	4	512	691	13,738	19,612
Ohio	23	15	1	—	2	4	165	215	3,963	6,149
Ind.	6	13	—	—	—	—	N	N	2,202	1,821
Ill.	6	13	1	—	—	—	92	231	4,124	5,689
Mich.	10	9	—	2	1	—	156	150	2,134	4,679
Wis.	10	13	3	9	—	—	99	95	1,315	1,274
W.N. CENTRAL	36	43	5	7	6	7	490	492	4,454	5,214
Minn.	4	19	2	3	2	—	240	161	731	1,239
Iowa	8	5	—	—	—	—	63	61	324	360
Mo.	12	3	2	4	2	2	100	152	2,674	2,446
N. Dak.	1	2	—	—	—	3	1	8	15	46
S. Dak.	2	1	—	—	—	—	20	19	101	80
Nebr.	5	7	1	—	1	—	29	46	106	326
Kans.	4	6	—	—	1	2	37	45	503	717
S. ATLANTIC	51	28	7	7	18	7	706	720	19,653	22,045
Del.	—	—	N	N	N	N	3	16	210	292
Md.	5	3	2	—	—	2	47	26	1,874	2,380
D.C.	—	—	—	—	—	—	13	27	573	694
Va.	2	1	2	5	4	—	141	99	2,388	2,641
W. Va.	—	1	—	—	—	—	8	9	193	230
N.C.	—	—	—	—	9	4	N	N	4,812	4,274
S.C.	1	2	—	—	—	—	26	19	2,500	2,731
Ga.	7	9	1	1	—	—	225	211	1,813	3,971
Fla.	36	12	2	1	5	1	243	313	5,290	4,832
E.S. CENTRAL	9	11	—	1	4	2	90	86	6,034	6,838
Ky.	—	4	—	1	3	2	N	N	1,015	703
Tenn.	6	2	—	—	1	—	39	35	2,185	2,340
Ala.	3	1	—	—	—	—	51	51	1,126	2,087
Miss.	—	4	—	—	—	—	—	—	1,708	1,708
W.S. CENTRAL	5	20	1	3	2	1	60	77	12,405	12,353
Ark.	1	1	—	1	—	—	21	37	1,265	1,040
La.	—	1	1	—	2	—	8	13	2,801	3,417
Okla.	1	3	—	—	—	—	31	27	1,346	1,277
Tex.	3	15	—	2	—	1	N	N	6,993	6,619
MOUNTAIN	24	30	7	4	1	—	307	335	3,236	3,270
Mont.	1	2	—	—	—	—	9	8	33	15
Idaho	3	6	4	1	—	—	25	49	31	22
Wyo.	—	—	1	—	—	—	6	3	16	16
Colo.	3	5	1	1	—	—	108	106	783	854
N. Mex.	—	5	1	1	—	—	12	18	141	287
Ariz.	6	4	N	N	N	N	53	66	1,320	1,358
Utah	4	5	—	—	—	—	74	64	200	108
Nev.	7	3	—	1	1	—	20	21	712	610
PACIFIC	34	36	—	1	—	—	680	728	9,866	9,883
Wash.	6	4	—	—	—	—	50	52	1,007	803
Oreg.	2	5	—	1	—	—	60	114	435	291
Calif.	20	23	—	—	—	—	529	518	8,061	8,150
Alaska	2	1	—	—	—	—	18	21	143	204
Hawaii	4	3	—	—	—	—	23	23	220	435
Guam	N	N	—	—	—	—	—	—	—	54
P.R.	—	—	—	—	—	—	10	9	118	63
V.I.	—	—	—	—	—	—	—	—	2	41
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages All serotypes		Age <5 years					
			Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	669	651	1	4	35	27	64	71
NEW ENGLAND	50	61	—	1	4	5	2	—
Maine	2	5	—	—	—	—	—	—
N.H.	—	10	—	—	—	2	—	—
Vt.	6	4	—	—	—	—	2	—
Mass.	19	30	—	1	—	2	—	—
R.I.	6	1	—	—	2	—	—	—
Conn.	17	11	—	—	2	1	—	—
MID. ATLANTIC	131	132	—	—	—	1	18	17
Upstate N.Y.	39	43	—	—	—	1	4	2
N.Y. City	21	23	—	—	—	—	5	5
N.J.	27	27	—	—	—	—	5	2
Pa.	44	39	—	—	—	—	4	8
E.N. CENTRAL	85	121	—	—	—	3	3	23
Ohio	46	42	—	—	—	2	2	7
Ind.	22	16	—	—	—	—	1	4
Ill.	4	32	—	—	—	—	—	8
Mich.	8	9	—	—	—	1	—	3
Wis.	5	22	—	—	—	—	—	1
W.N. CENTRAL	32	28	—	1	2	2	6	4
Minn.	13	11	—	—	2	2	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	15	11	—	—	—	—	4	3
N. Dak.	1	—	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	2	4	—	—	—	—	1	—
Kans.	1	1	—	—	—	—	—	1
S. ATLANTIC	193	155	—	—	7	4	12	10
Del.	—	—	—	—	—	—	—	—
Md.	31	30	—	—	2	1	2	—
D.C.	—	—	—	—	—	—	—	—
Va.	15	11	—	—	—	—	—	—
W. Va.	14	8	—	—	1	1	3	2
N.C.	25	17	—	—	2	1	—	—
S.C.	8	2	—	—	—	—	1	—
Ga.	51	46	—	—	—	—	4	8
Fla.	49	41	—	—	2	1	2	—
E.S. CENTRAL	31	22	—	—	1	—	6	5
Ky.	1	—	—	—	1	—	—	—
Tenn.	23	14	—	—	—	—	4	4
Ala.	7	8	—	—	—	—	2	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	37	24	1	—	2	3	5	—
Ark.	—	—	—	—	—	—	—	—
La.	15	8	1	—	—	—	5	—
Okla.	22	16	—	—	2	3	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	83	80	—	2	13	8	9	10
Mont.	—	—	—	—	—	—	—	—
Idaho	2	2	—	—	—	—	1	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	18	18	—	—	—	—	2	2
N. Mex.	9	19	—	—	4	3	—	4
Ariz.	36	34	—	—	7	5	1	1
Utah	7	5	—	2	—	—	3	1
Nev.	10	2	—	—	2	—	2	1
PACIFIC	27	28	—	—	6	1	3	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	14	14	—	—	—	—	3	—
Calif.	9	8	—	—	6	1	—	1
Alaska	1	1	—	—	—	—	—	—
Hawaii	3	4	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,023	1,749	1,600	1,706	171	237
NEW ENGLAND	162	263	91	113	3	4
Maine	—	7	4	1	—	—
N.H.	15	7	4	15	—	—
Vt.	—	5	1	1	3	1
Mass.	123	213	69	55	—	3
R.I.	5	6	—	1	—	—
Conn.	19	25	13	40	—	—
MID. ATLANTIC	164	217	382	252	31	35
Upstate N.Y.	28	25	37	17	8	1
N.Y. City	74	78	20	57	—	—
N.J.	27	49	261	77	—	—
Pa.	35	65	64	101	23	34
E.N. CENTRAL	98	156	109	140	37	18
Ohio	23	16	45	48	—	2
Ind.	6	10	5	8	7	1
Ill.	21	66	7	—	—	4
Mich.	38	46	52	68	30	11
Wis.	10	18	—	16	—	—
W.N. CENTRAL	36	41	74	105	14	1
Minn.	3	10	—	8	—	1
Iowa	5	8	11	4	—	—
Mo.	22	8	45	77	13	—
N. Dak.	—	—	—	1	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	2	10	11	9	—	—
Kans.	4	3	7	6	—	—
S. ATLANTIC	172	308	486	520	47	63
Del.	—	3	16	11	—	2
Md.	13	50	51	45	11	5
D.C.	2	3	—	5	—	1
Va.	23	24	62	58	7	9
W. Va.	—	1	7	3	2	3
N.C.	25	22	42	44	7	5
S.C.	6	15	36	29	1	4
Ga.	38	121	102	167	2	6
Fla.	65	69	170	158	17	28
E.S. CENTRAL	37	53	90	147	16	28
Ky.	3	8	24	16	—	11
Tenn.	20	28	36	60	5	5
Ala.	7	5	19	21	6	1
Miss.	7	12	11	50	5	11
W.S. CENTRAL	34	245	62	75	6	65
Ark.	1	36	13	35	—	—
La.	19	8	13	25	4	38
Okla.	2	13	5	14	—	2
Tex.	12	188	31	1	2	25
MOUNTAIN	115	138	144	120	6	8
Mont.	6	3	—	—	—	2
Idaho	8	7	3	3	—	—
Wyo.	—	—	—	3	—	—
Colo.	11	12	8	15	—	—
N. Mex.	5	5	5	6	—	2
Ariz.	68	89	105	60	—	2
Utah	12	20	15	16	4	—
Nev.	5	2	8	17	2	2
PACIFIC	205	328	162	234	11	15
Wash.	15	13	15	21	2	1
Oreg.	10	24	27	35	4	4
Calif.	171	282	118	174	5	8
Alaska	3	2	1	2	—	—
Hawaii	6	7	1	2	—	2
Guam	—	1	—	2	—	—
P.R.	1	8	3	13	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	286	313	120	125	1,400	2,133	266	315
NEW ENGLAND	13	6	2	5	48	219	7	25
Maine	1	—	—	1	2	27	—	—
N.H.	2	—	1	1	14	9	2	—
Vt.	—	—	—	—	1	7	—	1
Mass.	6	3	—	1	25	122	4	17
R.I.	1	1	—	—	1	18	1	2
Conn.	3	2	1	2	5	36	—	5
MID. ATLANTIC	85	66	25	30	1,009	1,581	67	71
Upstate N.Y.	24	13	7	7	158	502	15	10
N.Y. City	4	6	5	3	—	—	30	32
N.J.	17	10	5	11	416	301	14	14
Pa.	40	37	8	9	435	778	8	15
E.N. CENTRAL	59	78	17	18	32	55	15	23
Ohio	30	36	6	7	20	13	3	6
Ind.	1	8	1	2	2	—	—	3
Ill.	8	14	—	2	—	4	3	5
Mich.	16	18	5	5	2	—	7	4
Wis.	4	2	5	2	8	38	2	5
W.N. CENTRAL	10	8	10	3	40	22	12	20
Minn.	1	—	2	1	35	6	3	8
Iowa	—	2	3	1	2	5	2	1
Mo.	7	4	2	1	2	11	6	4
N. Dak.	1	1	2	—	—	—	—	1
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	—	—	—	—	—	—	1
Kans.	1	—	1	—	1	—	1	4
S. ATLANTIC	65	69	29	18	239	206	69	93
Del.	1	1	N	N	52	29	—	2
Md.	16	10	4	4	125	113	21	23
D.C.	1	2	—	—	1	4	2	4
Va.	4	5	1	1	22	6	7	7
W. Va.	3	2	—	1	2	1	1	—
N.C.	7	7	6	4	14	33	8	5
S.C.	1	2	—	—	5	1	3	5
Ga.	6	6	6	3	—	5	13	15
Fla.	26	34	12	5	18	14	14	32
E.S. CENTRAL	4	14	5	8	4	9	9	8
Ky.	1	3	—	2	—	2	2	1
Tenn.	1	6	2	5	4	2	5	1
Ala.	2	5	3	—	—	—	2	5
Miss.	—	—	—	1	—	5	—	1
W.S. CENTRAL	4	30	2	14	6	16	19	28
Ark.	1	—	—	1	—	—	1	1
La.	3	2	1	1	—	1	—	2
Okla.	—	2	—	—	—	—	2	1
Tex.	—	26	1	12	6	15	16	24
MOUNTAIN	25	21	—	2	1	5	14	12
Mont.	1	—	—	—	—	—	—	—
Idaho	1	1	—	1	—	1	—	—
Wyo.	2	4	—	—	—	2	1	—
Colo.	5	3	—	1	—	—	8	5
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	7	5	—	—	—	1	2	1
Utah	3	7	—	—	1	1	3	3
Nev.	5	1	—	—	—	—	—	2
PACIFIC	21	21	30	27	21	20	54	35
Wash.	—	2	2	5	—	2	3	1
Oreg.	N	N	2	4	1	7	1	4
Calif.	21	19	26	18	19	11	45	29
Alaska	—	—	—	—	1	—	2	—
Hawaii	—	—	—	—	N	N	3	1
Guam	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	387	506	30	33	22	17	—	—	335	456
NEW ENGLAND	27	25	1	3	—	—	—	—	26	22
Maine	1	7	—	—	—	—	—	—	1	7
N.H.	2	3	—	—	—	—	—	—	2	3
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	11	14	—	3	—	—	—	—	11	11
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	8	—	1	—	—	—	—	—	7	—
MID. ATLANTIC	53	72	15	19	3	5	—	—	35	48
Upstate N.Y.	13	24	1	3	2	3	—	—	10	18
N.Y. City	6	14	—	—	—	—	—	—	6	14
N.J.	14	10	—	—	—	—	—	—	14	10
Pa.	20	24	14	16	1	2	—	—	5	6
E.N. CENTRAL	34	48	9	8	3	3	—	—	22	37
Ohio	15	26	—	3	3	3	—	—	12	20
Ind.	5	9	—	—	—	—	—	—	5	9
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	9	5	9	5	—	—	—	—	—	—
Wis.	5	7	—	—	—	—	—	—	5	7
W.N. CENTRAL	27	22	1	—	1	2	—	—	25	20
Minn.	5	7	1	—	—	—	—	—	4	7
Iowa	9	4	—	—	1	1	—	—	8	3
Mo.	8	7	—	—	—	1	—	—	8	6
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	1	1	—	—	—	—	—	—	1	1
Nebr.	1	1	—	—	—	—	—	—	1	1
Kans.	3	2	—	—	—	—	—	—	3	2
S. ATLANTIC	70	95	2	2	4	2	—	—	64	91
Del.	—	1	—	—	—	—	—	—	—	1
Md.	7	5	1	—	2	—	—	—	4	5
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	7	3	—	—	—	—	—	—	7	3
W. Va.	2	3	—	—	—	—	—	—	2	3
N.C.	7	14	1	—	2	2	—	—	4	12
S.C.	9	8	—	—	—	—	—	—	9	8
Ga.	8	5	—	—	—	—	—	—	8	5
Fla.	30	51	—	—	—	—	—	—	30	51
E.S. CENTRAL	20	23	—	—	1	—	—	—	19	23
Ky.	7	3	—	—	1	—	—	—	6	3
Tenn.	9	8	—	—	—	—	—	—	9	8
Ala.	—	6	—	—	—	—	—	—	—	6
Miss.	4	6	—	—	—	—	—	—	4	6
W.S. CENTRAL	34	55	1	1	3	1	—	—	30	53
Ark.	8	10	—	—	—	—	—	—	8	10
La.	12	16	—	1	2	—	—	—	10	15
Okla.	6	3	1	—	1	1	—	—	4	2
Tex.	8	26	—	—	—	—	—	—	8	26
MOUNTAIN	25	26	—	—	3	3	—	—	22	23
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	1	2	—	—	—	—	—	—	1	2
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	7	9	—	—	—	—	—	—	7	9
N. Mex.	1	4	—	—	—	2	—	—	1	2
Ariz.	12	4	—	—	2	—	—	—	10	4
Utah	2	2	—	—	1	—	—	—	1	2
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	97	140	1	—	4	1	—	—	92	139
Wash.	18	6	1	—	3	1	—	—	14	5
Oreg.	21	29	—	—	—	—	—	—	21	29
Calif.	50	98	—	—	—	—	—	—	50	98
Alaska	2	2	—	—	—	—	—	—	2	2
Hawaii	6	5	—	—	1	—	—	—	5	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	3	—	—	—	—	—	—	—	3
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	4,317	2,618	1,285	1,647	165	142	6,130	7,184	2,492	3,169
NEW ENGLAND	205	437	211	119	1	5	370	338	53	62
Maine	9	—	15	11	N	N	19	18	1	1
N.H.	—	12	2	6	—	—	24	21	4	3
Vt.	41	21	12	5	—	—	25	17	3	1
Mass.	150	383	142	44	—	5	199	199	30	41
R.I.	5	9	4	8	1	—	15	12	2	1
Conn.	—	12	36	45	—	—	88	71	13	15
MID. ATLANTIC	484	651	148	177	11	15	740	943	281	360
Upstate N.Y.	170	458	96	78	—	—	193	198	80	146
N.Y. City	18	51	9	2	1	6	207	306	111	106
N.J.	73	37	N	N	2	—	111	167	74	67
Pa.	223	105	43	97	8	9	229	272	16	41
E.N. CENTRAL	1,141	412	12	4	2	4	584	1,179	144	281
Ohio	560	126	4	2	1	2	203	249	16	50
Ind.	87	20	1	1	—	1	39	101	25	46
Ill.	67	16	2	—	—	—	30	428	4	125
Mich.	50	30	5	1	1	1	163	186	79	32
Wis.	377	220	—	—	—	—	149	215	20	28
W.N. CENTRAL	559	142	67	144	10	3	464	457	192	99
Minn.	99	29	14	14	—	—	128	111	15	13
Iowa	157	26	18	13	—	—	80	84	35	29
Mo.	123	72	8	3	10	3	139	129	108	24
N. Dak.	34	4	4	15	—	—	8	11	2	1
S. Dak.	1	1	5	24	—	—	31	19	8	6
Nebr.	61	—	—	42	—	—	35	43	19	7
Kans.	84	10	18	33	—	—	43	60	5	19
S. ATLANTIC	303	135	429	741	114	93	1,822	1,542	462	873
Del.	2	—	—	9	1	2	7	14	1	3
Md.	56	34	78	87	5	2	144	114	21	30
D.C.	—	4	—	—	—	—	13	12	4	14
Va.	53	31	162	121	3	—	173	159	21	29
W. Va.	20	2	6	17	1	—	22	29	—	—
N.C.	21	26	131	176	80	73	314	216	50	121
S.C.	92	13	5	40	5	4	124	92	34	138
Ga.	12	7	44	86	11	10	303	242	137	168
Fla.	47	18	3	205	8	2	722	664	194	370
E.S. CENTRAL	111	26	27	62	2	16	294	386	300	161
Ky.	28	3	3	6	—	—	42	68	26	25
Tenn.	47	15	5	36	1	5	106	116	179	60
Ala.	26	4	19	16	1	2	110	123	76	55
Miss.	10	4	—	4	—	9	36	79	19	21
W.S. CENTRAL	89	89	316	338	3	3	376	674	468	740
Ark.	36	10	10	17	—	—	72	65	14	13
La.	3	2	—	—	1	3	88	83	30	82
Okla.	—	10	30	31	2	—	59	57	152	98
Tex.	50	67	276	290	—	—	157	469	272	547
MOUNTAIN	975	297	50	21	20	—	449	525	168	214
Mont.	236	4	—	3	1	—	21	26	2	3
Idaho	36	14	—	—	—	—	15	43	—	3
Wyo.	7	3	6	—	1	—	9	16	—	1
Colo.	435	153	—	—	—	—	118	125	27	34
N. Mex.	36	48	—	—	—	—	31	54	23	42
Ariz.	108	53	44	18	15	—	168	172	82	104
Utah	102	21	—	—	3	—	44	60	11	11
Nev.	15	1	—	—	—	—	43	29	23	16
PACIFIC	450	429	25	41	2	3	1,031	1,140	424	379
Wash.	118	94	—	—	—	—	86	55	17	18
Oreg.	199	97	—	—	—	2	64	91	21	17
Calif.	93	225	24	32	2	1	808	893	374	327
Alaska	12	9	1	9	—	—	14	25	4	3
Hawaii	28	4	—	—	—	—	59	76	8	14
Guam	—	—	—	—	—	—	—	9	—	16
P.R.	—	1	23	16	N	N	27	47	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,405	1,614	920	899	241	267	1,798	2,129	71	115
NEW ENGLAND	54	80	9	12	23	35	53	44	—	—
Maine	2	3	N	N	—	—	1	—	—	—
N.H.	4	9	—	—	1	N	4	1	—	—
Vt.	6	3	3	4	1	1	—	—	—	—
Mass.	36	63	—	3	21	32	43	27	—	—
R.I.	6	2	6	5	—	2	2	2	—	—
Conn.	—	—	—	—	U	U	3	14	—	—
MID. ATLANTIC	308	273	94	57	48	36	223	280	15	16
Upstate N.Y.	115	87	35	21	31	20	19	19	11	1
N.Y. City	35	51	U	U	U	U	143	171	3	7
N.J.	64	55	N	N	6	5	36	52	1	7
Pa.	94	80	59	36	11	11	25	38	—	1
E.N. CENTRAL	227	373	221	211	57	67	149	231	10	23
Ohio	81	95	150	162	28	31	60	65	2	1
Ind.	28	34	71	49	14	13	17	11	1	1
Ill.	2	106	—	—	11	—	45	96	1	4
Mich.	108	107	—	N	—	N	21	49	5	17
Wis.	8	31	N	N	4	23	6	10	1	—
W.N. CENTRAL	99	137	16	5	26	26	50	48	—	—
Minn.	37	62	—	—	15	14	6	7	—	—
Iowa	N	N	N	N	—	N	1	2	—	—
Mo.	34	30	15	4	1	6	38	29	—	—
N. Dak.	1	4	—	—	1	—	—	—	—	—
S. Dak.	7	8	1	1	—	—	—	—	—	—
Nebr.	8	10	—	—	2	4	1	5	—	—
Kans.	12	23	N	N	7	2	4	5	—	—
S. ATLANTIC	302	316	400	465	35	19	479	548	13	18
Del.	—	2	—	3	—	N	5	2	—	—
Md.	92	55	—	—	25	14	93	83	5	3
D.C.	2	2	11	6	2	4	32	24	—	1
Va.	18	16	N	N	—	N	25	11	3	1
W. Va.	3	11	30	46	8	1	2	3	—	—
N.C.	35	45	N	N	U	U	66	44	1	1
S.C.	9	26	—	44	—	N	20	40	—	4
Ga.	62	84	152	125	—	N	36	112	—	1
Fla.	81	75	207	241	—	N	200	229	4	7
E.S. CENTRAL	58	83	59	57	1	—	103	106	9	4
Ky.	17	30	9	13	N	N	6	14	—	—
Tenn.	41	53	50	44	—	N	39	44	7	1
Ala.	—	—	—	—	—	N	49	36	2	2
Miss.	—	—	—	—	1	—	9	12	—	1
W.S. CENTRAL	69	122	57	28	30	61	334	323	16	27
Ark.	7	4	6	4	3	4	14	14	—	3
La.	4	1	51	24	8	16	52	67	2	—
Okla.	49	19	N	N	13	16	13	7	1	2
Tex.	9	98	N	N	6	25	255	235	13	22
MOUNTAIN	258	197	36	15	21	23	96	109	8	4
Mont.	—	—	—	—	—	—	5	—	—	—
Idaho	1	3	N	N	—	N	9	8	—	—
Wyo.	1	5	12	4	—	—	—	1	—	—
Colo.	117	33	N	N	20	21	9	19	—	—
N. Mex.	16	42	—	5	—	—	7	31	1	1
Ariz.	94	100	N	N	—	N	42	44	7	3
Utah	28	14	23	4	1	2	1	2	—	—
Nev.	1	—	1	2	—	—	23	4	—	—
PACIFIC	30	33	28	49	—	—	311	440	—	23
Wash.	N	N	N	N	N	N	50	22	—	—
Oreg.	N	N	N	N	—	N	8	11	—	—
Calif.	—	—	N	N	N	N	248	403	—	23
Alaska	—	—	—	—	—	N	3	—	—	—
Hawaii	30	33	28	49	—	—	2	4	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	41	38	3	2
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 16, 2005, and April 17, 2004 (15th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	2,059	3,261	44	69	6,691	6,429	—	—	—
NEW ENGLAND	70	92	2	9	112	268	—	—	—
Maine	6	3	—	—	92	43	—	—	—
N.H.	3	4	—	—	—	—	—	—	—
Vt.	—	—	—	—	19	225	—	—	—
Mass.	47	52	1	8	1	—	—	—	—
R.I.	2	13	—	1	—	—	—	—	—
Conn.	12	20	1	—	—	—	—	—	—
MID. ATLANTIC	521	505	13	18	1,446	22	—	—	—
Upstate N.Y.	51	60	2	1	—	—	—	—	—
N.Y. City	277	250	1	7	—	—	—	—	—
N.J.	121	110	3	7	—	—	—	—	—
Pa.	72	85	7	3	1,446	22	—	—	—
E.N. CENTRAL	331	284	2	4	2,300	2,432	—	—	—
Ohio	67	55	—	1	520	634	—	—	—
Ind.	37	43	—	—	N	N	—	—	—
Ill.	157	121	—	—	8	—	—	—	—
Mich.	49	43	1	3	1,591	1,537	—	—	—
Wis.	21	22	1	—	181	261	—	—	—
W.N. CENTRAL	113	97	1	2	63	94	—	—	—
Minn.	45	34	1	1	—	—	—	—	—
Iowa	11	11	—	—	N	N	—	—	—
Mo.	34	31	—	1	2	2	—	—	—
N. Dak.	2	2	—	—	9	67	—	—	—
S. Dak.	5	3	—	—	52	25	—	—	—
Nebr.	5	6	—	—	—	—	—	—	—
Kans.	11	10	—	—	—	—	—	—	N
S. ATLANTIC	401	604	7	8	643	795	—	—	—
Del.	—	7	—	—	2	3	—	—	—
Md.	62	55	1	2	—	—	—	—	—
D.C.	22	6	—	—	6	11	—	—	—
Va.	63	36	—	2	67	210	—	—	—
W. Va.	8	6	—	—	432	410	—	—	N
N.C.	45	55	1	2	—	N	—	—	—
S.C.	44	44	—	—	136	161	—	—	—
Ga.	28	196	2	—	—	—	—	—	—
Fla.	129	199	3	2	—	—	—	—	—
E.S. CENTRAL	129	140	1	1	—	—	—	—	—
Ky.	32	17	1	—	N	N	—	—	—
Tenn.	68	43	—	1	—	—	—	—	—
Ala.	29	47	—	—	—	—	—	—	—
Miss.	—	33	—	—	—	—	—	—	—
W.S. CENTRAL	57	545	3	7	1,044	1,850	—	—	—
Ark.	23	36	—	—	—	—	—	—	—
La.	—	—	—	—	77	33	—	—	—
Okla.	34	41	—	—	—	—	—	—	—
Tex.	—	468	3	7	967	1,817	—	—	—
MOUNTAIN	46	127	2	2	1,083	968	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	39	15	—	—	—
Colo.	8	29	—	—	763	719	—	—	—
N. Mex.	1	10	—	—	58	27	—	—	—
Ariz.	34	49	1	1	—	—	—	—	—
Utah	3	14	1	1	223	207	—	—	—
Nev.	—	25	—	—	—	—	—	—	—
PACIFIC	391	867	13	18	—	—	—	—	—
Wash.	62	57	—	1	N	N	—	—	—
Oreg.	31	26	1	—	—	—	—	—	—
Calif.	254	744	8	12	—	—	—	—	—
Alaska	11	9	—	—	—	—	—	—	—
Hawaii	33	31	4	5	—	—	—	—	—
Guam	—	14	—	—	—	22	—	—	—
P.R.	—	14	—	—	65	104	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

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† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending April 16, 2005 (15th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	546	379	120	28	8	11	52
Boston, Mass.	171	118	37	6	5	5	17
Bridgeport, Conn.	26	21	4	—	1	—	—
Cambridge, Mass.	12	8	1	3	—	—	3
Fall River, Mass.	23	19	1	2	1	—	5
Hartford, Conn.	57	34	18	4	—	1	8
Lowell, Mass.	15	14	1	—	—	—	1
Lynn, Mass.	5	4	—	1	—	—	1
New Bedford, Mass.	27	21	3	2	—	1	3
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	66	44	15	4	1	2	2
Somerville, Mass.	3	3	—	—	—	—	—
Springfield, Mass.	40	26	12	2	—	—	3
Waterbury, Conn.	32	20	11	1	—	—	4
Worcester, Mass.	69	47	17	3	—	2	5
MID. ATLANTIC	2,269	1,569	490	124	49	37	138
Albany, N.Y.	40	30	9	—	—	1	1
Allentown, Pa.	25	20	2	2	—	1	1
Buffalo, N.Y.	95	68	19	6	1	1	15
Camden, N.J.	27	19	5	3	—	—	1
Elizabeth, N.J.	18	14	2	1	1	—	4
Erie, Pa.	39	28	9	1	1	—	4
Jersey City, N.J.	46	27	14	3	1	1	—
New York City, N.Y.	1,179	821	254	60	23	21	58
Newark, N.J.	41	16	15	7	2	1	1
Paterson, N.J.	12	6	4	2	—	—	—
Philadelphia, Pa.	379	249	89	22	13	6	26
Pittsburgh, Pa.§	26	17	4	1	—	4	1
Reading, Pa.	19	15	2	1	1	—	2
Rochester, N.Y.	128	92	26	4	5	1	10
Schenectady, N.Y.	27	26	—	1	—	—	1
Scranton, Pa.	31	24	4	3	—	—	2
Syracuse, N.Y.	67	48	14	4	1	—	9
Trenton, N.J.	27	17	7	3	—	—	—
Utica, N.Y.	15	13	2	—	—	—	2
Yonkers, N.Y.	28	19	9	—	—	—	—
E.N. CENTRAL	2,228	1,484	489	156	43	56	195
Akron, Ohio	70	48	15	3	2	2	8
Canton, Ohio	38	27	8	3	—	—	7
Chicago, Ill.	335	184	94	40	9	8	29
Cincinnati, Ohio	98	64	21	4	5	4	3
Cleveland, Ohio	278	213	39	17	4	5	18
Columbus, Ohio	227	148	52	16	2	9	25
Dayton, Ohio	117	82	24	8	1	2	17
Detroit, Mich.	173	100	52	14	3	4	13
Evansville, Ind.	50	31	14	3	1	1	2
Fort Wayne, Ind.	76	58	8	6	1	3	11
Gary, Ind.	12	5	5	—	1	1	1
Grand Rapids, Mich.	81	63	12	4	2	—	13
Indianapolis, Ind.	226	134	63	15	6	8	17
Lansing, Mich.	40	33	7	—	—	—	2
Milwaukee, Wis.	102	64	28	6	1	3	5
Peoria, Ill.	41	27	11	—	1	2	5
Rockford, Ill.	54	43	7	3	1	—	1
South Bend, Ind.	50	39	6	3	1	1	2
Toledo, Ohio	82	62	11	5	1	3	9
Youngstown, Ohio	78	59	12	6	1	—	7
W.N. CENTRAL	557	369	119	27	18	21	57
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	31	23	5	1	1	1	1
Kansas City, Kans.	31	18	11	2	—	—	8
Kansas City, Mo.	76	55	12	4	1	3	8
Lincoln, Nebr.	46	32	9	1	1	3	4
Minneapolis, Minn.	68	42	12	4	5	5	4
Omaha, Nebr.	92	65	16	5	5	1	13
St. Louis, Mo.	61	35	18	2	1	3	8
St. Paul, Minn.	55	36	12	3	—	4	6
Wichita, Kans.	97	63	24	5	4	1	5
S. ATLANTIC	1,326	839	329	103	23	32	101
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	170	103	49	12	2	4	24
Charlotte, N.C.	120	76	26	11	4	3	13
Jacksonville, Fla.	153	97	33	19	—	4	10
Miami, Fla.	74	52	14	7	1	—	4
Norfolk, Va.	55	33	13	2	3	4	2
Richmond, Va.	53	36	10	2	1	4	5
Savannah, Ga.	50	39	9	—	—	2	6
St. Petersburg, Fla.	28	18	7	—	1	2	3
Tampa, Fla.	216	148	49	13	2	4	17
Washington, D.C.	394	229	116	35	9	5	16
Wilmington, Del.	13	8	3	2	—	—	1
E.S. CENTRAL	931	623	217	45	24	22	80
Birmingham, Ala.	224	151	55	3	7	8	31
Chattanooga, Tenn.	83	60	19	1	1	2	5
Knoxville, Tenn.	126	84	26	9	6	1	2
Lexington, Ky.	81	63	10	3	5	—	8
Memphis, Tenn.	146	93	38	11	—	4	7
Mobile, Ala.	61	44	11	4	1	1	6
Montgomery, Ala.	48	28	13	4	2	1	2
Nashville, Tenn.	162	100	45	10	2	5	19
W.S. CENTRAL	2,239	1,502	471	172	54	40	125
Austin, Tex.	106	66	23	12	3	2	12
Baton Rouge, La.	26	17	7	1	—	1	—
Corpus Christi, Tex.	61	46	12	2	—	1	5
Dallas, Tex.	238	139	52	30	9	8	18
El Paso, Tex.	79	68	8	2	—	1	9
Ft. Worth, Tex.	121	82	24	10	3	2	6
Houston, Tex.	400	237	98	42	13	10	23
Little Rock, Ark.	66	43	16	5	—	2	1
New Orleans, La.	718	495	150	53	15	5	33
San Antonio, Tex.	225	162	42	7	9	5	16
Shreveport, La.	63	44	15	3	1	—	2
Tulsa, Okla.	136	103	24	5	1	3	—
MOUNTAIN	1,183	794	231	94	36	27	81
Albuquerque, N.M.	124	97	20	5	1	1	12
Boise, Idaho	45	30	9	2	2	2	3
Colo. Springs, Colo.	76	58	12	4	—	2	1
Denver, Colo.	106	58	21	15	7	5	8
Las Vegas, Nev.	279	173	70	24	6	6	18
Ogden, Utah	30	19	8	2	—	1	1
Phoenix, Ariz.	191	121	39	15	9	6	10
Pueblo, Colo.	35	28	5	2	—	—	3
Salt Lake City, Utah	138	95	24	14	3	2	17
Tucson, Ariz.	159	115	23	11	8	2	8
PACIFIC	1,770	1,268	345	97	36	24	194
Berkeley, Calif.	18	11	3	3	—	1	3
Fresno, Calif.	132	101	20	7	1	3	10
Glendale, Calif.	19	18	1	—	—	—	5
Honolulu, Hawaii	76	54	20	—	1	1	9
Long Beach, Calif.	75	52	16	5	2	—	14
Los Angeles, Calif.	304	214	53	19	10	8	30
Pasadena, Calif.	21	16	3	1	1	—	7
Portland, Oreg.	117	81	21	12	2	1	11
Sacramento, Calif.	187	141	34	8	3	1	14
San Diego, Calif.	179	131	32	8	5	3	14
San Francisco, Calif.	78	48	25	4	—	1	10
San Jose, Calif.	236	169	47	12	7	1	35
Santa Cruz, Calif.	42	31	9	1	1	—	9
Seattle, Wash.	127	84	29	9	2	3	10
Spokane, Wash.	48	37	8	3	—	—	6
Tacoma, Wash.	111	80	24	5	1	1	7
TOTAL	13,049¶	8,827	2,811	846	291	270	1,023

U: Unavailable. —: No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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